STUDY REPORT

Assessing the sustainability of gains made in diagnosis and management of severe febrile illness in children under-five in the Lake Zone, Tanzania

JULY 2015

This study report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Eliphace Mkumbo of Management Sciences for Health (MSH), Festus Kalokola and Victor Masbayi of URC, and Christine Skladany (Consultant) under The Diagnosis and Management of Severe Febrile Illness (Tibu Homa) Program. The Tibu Homa Program is managed by URC under Cooperative Agreement No. 621-A-00-11-00011-00 and is made possible by the generous support of the American people through USAID.

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ACRONYMS

ACT	Artemisinin-based combination therapy
AMO	Assistant Medical Officer
CCHPs	Comprehensive Council Health Plans
CDC	Center for Diseases Control
CHF	Community Health Funds
CHMT	Council Health Management Team
CHSBs	Council Health Services Boards
CM	Case Management
DC	District Commission
DDH	District Designated Hospital
DED	District Executive Director
DMIFPs	District Malaria and IMCI Focal Persons
dIMCI	Distance Integrated Management of Childhood Illnesses
DMO	District Medical Officer
DM	Data Management
GOT	Government of Tanzania
HCWs	Health Care Workers (facility-based)
HFGCs	Health Facility Governing Committees
HMTs	Hospital Management Teams
HMTCs	Hospital Medicines and Therapeutic Committees
HSS	Health Strengthening Services
HTI	Health Training Institute
ICT	Information Communication and Technology
IMCI	Integrated Management of Childhood illnesses
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MRDTs	Malaria Rapid Diagnostic Test
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
MSH	Management Sciences for Health
NMCP	National Malaria Control Program
NSSF	National Social Security Fund
RHMT	Regional Health Management Team
SCM	Supply Chain Management
THP	Tibu Homa Program
URC	University Research Co., LLC
USAID	United States Agency for International Development

I. Executive Summary

a. Introduction

Tanzania is among the six countries with the highest malaria morbidity and mortality [1] rate in the world, especially in children under the age of five (5). The USAID-funded Tibu Homa (Treat Fever) program in the Lake Zone of Tanzania has the overall goal of reducing morbidity and mortality in children under five due to severe febrile illness. The main objective is to treat all children under-five within 24 hours of onset of fever. The correct diagnosis and treatment of children under five relies on a system of trained health care workers and Regional and Council Health Management teams (R/CHMT) (the health facility managers) who support a framework for ongoing mentoring, supervision in case management, logistics management and quality improvement methods. The Tibu Homa Program provided worked with the R/CHMTs to provide classroom and on-the-job training. On the job training was through monthly supportive supervision/coaching, and clinical & logistic mentorship. The program assessed the sustainability of its efforts within the R/CHMTs and the established Pediatric Quality Improvement Teams (PQIT) that help to monitor improvement efforts within each of the program-supported facilities.

b. Overview of Assessment

The overall purpose was to identify and document the factors enhancing or limiting the capacity of the R/CHMTs to supervise and mentor facilities, the performance of PQITs, and the sustainability of gains made by the Tibu Homa Program. A survey tool was developed to help identify trends in R/CHMT capacity and gains made. A sample of R/CHMT members were identified and a total of 21 surveys returned, representing a cross-section of members from a variety of health professionals. To assess the functionality and performance of PQITs, a sample size of 239 health facilities in six (6) regions was selected to ensure a range of facilities covered at different levels: dispensaries, health centers and hospitals. A program–designed checklist was used to cross-reference current capacity against the existing obligations of PQITs. To assess sustainability of gains, the same R/CHMT survey was used and a face-to-face survey conducted among members of the targeted PQITs. Fourteen (14) respondents in total participated from PQITs in 6 regions.

c. Summary key findings

Key Findings for Regional and Council Health Management Team capacity

The data clearly indicates an increase in knowledge among R/CHMTs and reported improvements in Case Management (CM), Supply Chain Management (SCM) and Data Management associated with regular Supportive Supervision and Mentorship (SS&M) opportunities. The average reported frequency of SS and Mentorship is on a quarterly basis in the majority of respondents (70%) while on a monthly basis for (25%) of respondents. The coverage for supportive supervision and mentorship to health facilities has been excellent in two of the three start-up regions of Tibu Homa Program (Kagera 92% and Mwanza 100%). Meanwhile, Geita, one of the three recently-added regions, reports only 30% coverage. The addition of new data columns in the Health Management Information System (HMIS) is

[1] The most recently published Tanzania Demographic and Health Survey (TDHS 2010) revealed that the national under five mortality rate had declined from 112 per 1000 live births in 2003/04[1] to 81 per 1000 live births in 2010[1]. However, in the Lake Zone region of Tanzania, it remains high with an estimated under five mortality rate of 109 per 1000 live births in 2010[1]. The high under five mortality rate in the Lake Zone is closely linked to lack of successful child survival interventions, including inadequate malaria control efforts in the region.

accepted by respondents and can be said to be a success in helping to enhance data collection and use to improve patient care.

Key Findings for Pediatric Quality Improvement Teams (PQIT) Functionality
The data provides evidence from 5 of 6 regions covered by the Tibu Homa Program on different themes: PQIT leadership; Availability of essential medicines and medical products/equipment; Health Management Information System (HMIS); Human Resources for Health; and, Health service organization and delivery. On all fronts, major improvements were noted through data trends including availability of essential medicines (10 + tracer medicines available in 98% of facilities); improvements in health information available through use of Out Patient Department (OPD) cards (63 % and 89 %) available in Kagera and Mwanza respectively, the overall average was 62 %. Availability of Extra columns in HMIS evident: 84% in Simiyu and 98% in Kagera.

Key Findings for Sustainability of gains made
The key gains noted by both PQITs and R/CHMTs are: the use of IMCI guidelines (CM); improved availability of medicines (SCM); and improved documentation (Data Management).The gains noted are consistent with other data provided in the other areas of the survey hence this offers a strong predilection of which improvements will remain beyond the life of the Program. The weakest gains relate to financial management and resource mobilization. Financial management training was completed in three regions, however, the weakness arises in the implementation of action points on the agreed marketing plans. There is more potential for sustainability around mobilizing resources through the Community Health Funds (CHF). The CHF is a means to help supplement recurrent costs in health care facilities. There are some examples of health care facilities reaching out to work with other partners, however, this does not represent a strong trend. Meanwhile, among PQITs, health facilities are introducing and experimenting with different interventions to improve overall Case Management.

d. Conclusion

Key conclusion focus around health managers' improved performance in SS&M and gains made in key program areas.

- Health Managers report they are conducting SS&M on a regular basis. This is a good sign that CM improvements will be sustained. However, the percentage of facilities covered / reached through these visits remains low.
- Health Managers appear to care about the training of Health Care Workers (HCWs) however there appears limited effort to ensure that funds are allocated for this purpose. The efforts to mobilize resources to cover these recurrent costs appears weak and limited.
- The addition of data columns in the HMIS in Tibu Homa-supported facilities is viewed as positive and useful.
- The follow up from Financial Management and Resource Mobilization training appears weak and intermittent.
- There are inadequate data recording tools and a corresponding lack of supportive culture in using the tools.
- R/CHMTs and PQITS clearly value efforts to enhance CM and SCM; the use of IMCI guidelines, improved availability of essential medicines and supplies, and improved documentation and use of data for decision-making.
- The relationship between PQITs and the Facility management does not yet support an effective exchange and sharing of the PQIT experiences on a regular basis.

e. Recommendations

As a result of key conclusions, the following recommendations flow:

- Health managers and the Regional Medical Officers/District Medical Officers (RMOs/DMOs) should apportion more of their time for conducting and training in SS&M.
- Continue efforts to build the capacity of R/CHMT in mobilizing resources; a specific training item in this area should be integrated into the Comprehensive Council Health Plans (CCHP).
- Mobilize and expand information-sharing of good practices of CHF strengthening activities, in particular, so experiences of increased membership numbers can be seen as an opportunity to ensure other funding opportunities to cover recurrent costs.
- Advocate to Ministry of Health and Social Welfare (MOHSW) the inclusion of additional data columns in HMIS based on the positive feedback from the assessment.
- Promote and highlight the efforts of HCWs who are role models in improving SCM and Data Management.
- R/CHMTs to ensure monitoring of the availability and use of IMCI guidelines; stock levels of medicines and supplies; collection and use of data and regular meetings between facility management and the PQITs.

II. Introduction

The 2010 Tanzania Demographic and Health Survey (DHS)[2] showed a national under-five and infant mortality of 81 and 51 per 100,000 live births and 109 and 64 per 100,000 live births respectively for the Lake Zone. This prompted United States Agency for International Development (USAID) and Ministry of Health and Social Welfare (MOHSW) to design the Tibu Homa Program to improve diagnosis and management of severe febrile illness in children under-five years of age in the Lake Zone[3].

Tibu Homa is implemented by the University Research Company (URC) in collaboration with Management Sciences for Health (MSH) and AMREF Health Africa. The program strategy is partnering with the Tanzania Ministry of Health and Social Welfare (MoHSW), and Regional and District Health teams to transform the current presumptive diagnosis and management of febrile illness into a system where rapid diagnostic tests play a central role, increasing correct diagnosis and treatment. This is done by classroom training of HCWs in case management, logistics management, quality improvement methods, (using the "Plan-Do-Study-Act cycles"), providing on-the-job training through monthly supportive supervision/coaching, and clinical & logistic mentorship in collaboration with the R/CHMTs. This collaborative effort in training and supportive supervision "ensures that workers know exactly what tasks they are expected to perform, have the necessary resources to perform these tasks, and receive feedback that assists them in achieving their tasks."[4]

At the facility level, the program helped establish and train PQITs in CM and in SCM. To ensure that classroom trainings are transformed into good practices, the program trained R/CHMTs (in SS & M) to conduct ongoing "on-the job" supervision & mentorship to improve the quality of care to children under five years of age. The aim is to improve HCWs' knowledge and skills, to institutionalize the use of standard case management guidelines, to reorganize health system structures and to bring about efficiency in service provision, to ensure constant availability of medicines and supplies, to improve patient information documentation and to make use of data in decision-making.

PQITs received regular monthly SS&M visits. Data were continuously collected through supportive supervision checklists which included functionality of the PQITs and the feedback provided. Data so far indicate that health facility PQITs are practicing case management improvements with considerable varying levels of performance.

The R/CHMTs and PQITs have an important role to play in ensuring sustained performance and maintenance of gains made under the program. It is with this background that the Tibu Homa Program is looking at the capacity of R/CHMTs to supervise and mentor, the functionality and performance of PQITs, and the sustainability of gains made, to date.

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[2]Tanzania Demographic and Health survey, National Bureau of Statistics, Dar es Salaam, Tanzania; ICF Macro, Calverton, Maryland USA, April 2011

[3]Tibu Homa is operational in Mwanza, Geita, Mara, Kagera, Shinyanga and Simiyu.

[4] Bradley et-al (2013) District health managers' perceptions of supervision in Malawi and Tanzania. Retrieved from http://www.human-resources-health.com/content/11/1/43

1. Overview of the Assessment

The Tibu Homa Program conducted the sustainability assessment in an effort to gauge the success of its work to improve capacity of R/CHMTs, the functionality of PQITs and sustainability of gains made to date. The assessment, designed and led by Tibu Homa staff, took place in May 2015. The team was supported by professional data collectors. A health statistician supported data entry in late May 2015 and the Tibu Homa Monitoring and Evaluation Consultant supported data quality control and analysis.

The ultimate challenge for Tibu Homa is to ensure that the interventions implemented and the gains made continue after the program has ended. Sustainability is one of the three key objectives of the program, and was included as an intervention component from planning and design stage[i]. At the start of the program, the team met with stakeholders and agreed on the following as key objectives:

a. Engaging the Integrated Management of Childhood Illnesses Unit (IMCI) and the National Malaria Control Program (NMCP) at national, regional and council levels, the Zonal Health Resource Center (ZHRC) in the Lake Zone and the R/CHMTs to ensure institutionalization of improvement gains such as supportive supervision, data management, and CM & SCM trainings.
b. Working with PQITs to improve CM ownership at the facility level by ensuring continued availability of Malaria Rapid Diagnostic tests (mRDTs) and anti-malarial drugs and a functional system to continuously train facility-based personnel on CM.
c. Building the capacity of R/CHMTs in financial management with a special focus on planning, budgeting, and resource mobilization.
d. Increasing the capacity and commitment of regional and particularly district officers to monitor and supervise CM
e. Ensuring the support of the private sector, including the potential mobilization of additional resources, thus creating a mechanism for accountability (including incentives) for the quality of CM.
f. Improving data management and plans at all levels.

The Tibu Homa Program was initially designed as a five-year program but is ending eight months earlier than planned due to reduced donor funding. It is appropriate at this stage that the program determines the extent to which the interventions and gains made are being sustained and document the factors enhancing or limiting sustainability.

1 Purpose of the Assessment

The overall purpose of the assessment was to identify and document the factors enhancing or limiting the capacity of the R/CHMTs to supervise and mentor facilities, the performance of PQITs, and the sustainability of gains made by the Tibu Homa Program in the Lake Zone.

The specific objectives are:

- To assess and document the capacity of R/CHMTs to supervise and mentor health facilities on improved case management in children under-five years of age.
- To assess and document the functionality and performance of PQITs in improving case management in children under-five years of age.
- To assess and document the extent to which gains made to date are being sustained by the R/CHMTs and health facilities.

2 Definitions

For purposes of this assessment, the terms capacity, viability, and sustainability are defined as follows:

Capacity: refers to the ability of R/CHMTs and health facilities to maintain:

a. Leadership and governance as measured by number of facilities with in-charges trained in IMCI and with functional PQITs
b. Financial management as measured by number of R/CHMTs with members trained in financial management
c. Human resources as measured by facilities with HCWs trained in IMCI
d. Good facility level performance as measured by facilities collecting and using data.

Viability: refers to availability of R/CHMT members and facility-in-charges trained in management skills and health facilities with functional PQITs. The assessment will also consider community capacity and viability in seeking care for febrile illness within 24 hours.

Sustainability: is defined as holding the gains made and evolving as required without going back to the old way of doing things. The assessment will look into the contribution of R/CHMTs' capacity and functionality of PQITs as key contributors to sustaining gains made and will identify other variables that might have enhanced or limited the sustainability of gains made.

3 Methodology

3.1 Ethics

Approval of the Sustainability Assessment protocol was sought from the Lake Zone IRB. Permission was also sought from Regional Medical Officers (RMOs), District Medical Officers (DMOs) and Medical Officers (MOs)/Clinicians in-charge (IC) of selected facilities. A signed consent form was required for all interviewed participants.

3.2 Study Design

This assessment looks at three key parameters. Two of which -- R/CHMTs capacity and performance of PQITs --- are assumed to have an influence on the third parameter -- the sustainability of gains made. Therefore the methodology of this assessment used a slightly different approach for each area of inquiry.

In order to assess **R/CHMT's capacity**, the methodology used was a survey of R/CHMT members administered by a trained data collector. A purposeful sampling approach was used to select all the R/CHMTs, HFs in-charges and PQITs members that were involved in defining and developing a sustainability strategy (also relevant for Sustainability of Gains assessment). In this case the RHMTs of Kagera, Mwanza, and Mara, CHMTs of Geita, Musoma Rural and Missenyi and PQITs of Mugana, Butiama, and Mkula Hospitals were selected. In each of the R/CHMTs and PQITs two-four members were purposefully selected for in-depth interviews or focus group discussions, the criteria for selection being information rich cases. Twenty (20) surveys were anticipated and twenty-one (21) were returned. This number was based on an average of 2 to 4 individuals interviewed in the targeted R/CHMTs. [5]The survey captured data on practice of new skills acquired and also assessed Management and Accountability according to four areas of inquiry: leadership and governance; financial management; trained human resources; and, appropriate/good facility level data collection/use.

[5] Excerpt from Sustainability Assessment protocol, April 2015.

To assess the **functionality and performance of PQIT's,** a sample size of 241 health facilities in six (6) regions was selected to ensure a range of facilities covered at different levels: dispensaries; health centers; and, hospitals. The use of the checklist underscores the existing obligations of PQITs as part of MoHSW network.

The survey was undertaken in five regions of Tibu Homa Program. The three original regions of work -- Kagera, Mara and Mwanza — and then two of the three expansion regions of Shinyanga and Simiyu. Geita was not included in this assessment given its late addition as a program region. This was done to ensure a comparison of a longer period of time as PQITs to internalize training/access to Tibu Homa support (compared to shorter period of time with the expansion regions) and to gauge the effectiveness of the program's interventions. The survey was undertaken in May 2015 by Tibu Homa data collectors and 241 facilities in total were assessed. [6] These facilities included a range of health centers, hospitals and dispensaries

A sample size of 241 supportive supervision checklists (previously used for PQIT supervision) were reviewed and analyzed for the assessment. The checklists were divided based on the proportion[7] of the level of health facilities reached by the program. This sample included an oversampling of 10% taking into consideration non-responses. The sample size was calculated for a cross-sectional design at 95% confidence level and 5% margin of error. All of the supported health facilities had an equal chance of being selected based on their respective levels and a simple random sampling technique was applied to determine the health facilities whose last supportive supervision and mentorship checklist will be picked for assessment.

To assess overall "g**ains made"** in key areas of Tibu Homa work (CM, SCM and Data Management), the methodology used was a survey tool administered by a trained data collector. The survey included open-ended questions to allow for a broad range of responses and probed on key themes relevant to R/CHMT and PQIT work to determine level of understanding of key challenges and key plans to address. Likewise, a target number of 2 to 4 individuals per PQIT were interviewed.

Figure 1: Number of reviewed checklists by level of facility (PQIT)

Facility level	% of sample per level	Total checklists sampled
Hospital	11.2%	27
Health Centre	23.7%	57
Dispensary	65.1%	157
Total		241

III Key Findings

[6] A minimum sample of 217 supportive supervision checklists (previously used for PQIT supervision) will be estimated for the assessment, with checklists to be divided based on the proportion of the level of health facilities reached by the program. An oversampling of 10% will be added to take into consideration non responses, making a total of 239 checklists (approx. 240). This sample size has been calculated for a cross sectional design at 95% confidence level and 5% margin of error.

[7] The proportion of Hospitals, Health Centers and Dispensaries covered by the program is 10%, 17%, and 73% respectively

1 R/CHMT Capacity

1.1 Survey Background

This portion of the survey was designed to assess and document the capacity of R/CHMTs to supervise and mentor health facilities on improved case management in children under-five years of age. Capacity, for the purpose of this assessment, is defined by the following four characteristics:

- Leadership and governance as measured by number of facilities with in-charges trained in IMCI and with functional PQITs
- Financial management as measured by number of R/CHMTs with members trained in financial management
- Human resources as measured by facilities with HCWs trained in IMCI
- Good facility level performance as measured by facilities collecting and using data.

1.2 Profile of R/CHMT respondents

A total of 21 survey forms were completed after meeting R/CHMT representatives: 11 participants from RHMTs and 10 participants from CHMTs. The interviews were conducted individually but the responses indicate a facility-specific pattern. The data is not gender-disaggregated due to the small number of participating respondents; a total of 7 / 21 interviews were held with female members of R/CHMTs.

1.3 Analysis of Training Trends in Supportive Supervision, Mentorship and Data Collection

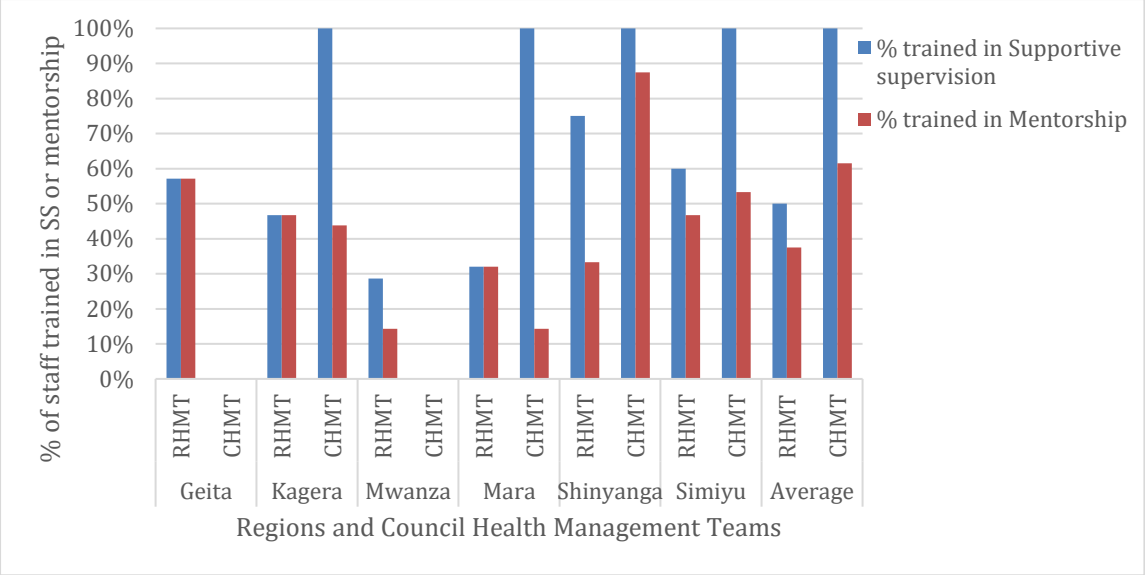
CHMTs had more staff trained (4 districts) in SS&M while RMHTs had less. The difference in numbers may be attributed to the fact that CHMTs often co-opt some of the HCWs from District Hospitals which then makes CHMT membership relatively bigger than RHMTs.

The data clearly indicates an increase in knowledge among R/CHMTs and reported improvements in CM, SCM and Data Management associated with regular SS&M. The average reported frequency of SS&M is on a quarterly basis in the majority of respondents (70%) while on a monthly basis for (25%) of respondents. Respondents indicate that they are all currently doing SS & M to a high degree -- 100% leading Supportive Supervision and 87% leading Mentorship visits at a quarterly basis (70%) and once a month (23.5%). Three regions achieved less than 50% in coverage for training (Shinyanga, Geita and Mara) and one region (Simiyu) in the mid-zone (57% coverage) and two regions achieved high coverage rates (Kagera, 92% and Mwanza, 100%) of facilities reached. As for training in SS&M a small number of R/CHMTs are trained in Shinyanga (3) and Simiyu (4).

The coverage of offered SS & M training to health facilities has been excellent in two of the three initial or start-up regions of Tibu Homa Program (Kagera, 92% and Mwanza, 100%) meanwhile, Geita, one of the three recently-added regions, reports only 30% coverage. The addition of new data columns in the HMIS has been seen favorably by respondents and can be qualified as a success in helping to enhance data collection and use to improve patient care. *See next section.*

1.4 Survey Results

Figure 2: Bar chart of % of staff in R/CHMT trained in SS & M per region



1.5 Average staff trained in SS & M

Only two (2) regions reported training rates of 60 % and 75% of staff trained at RHMT in supportive supervision (Shinyanga-75% and Simiyu-60%). Four districts reported 100% training rate for staff in 4 regions of CHMT staff in supportive supervision.

Shinyanga reported 87.5% training rate in mentorship for staff. Meanwhile, the second closest was Simiyu with a passing grade of 53% of staff trained in mentorship. Only Geita and Simiyu achieved training rates in the 50% range.

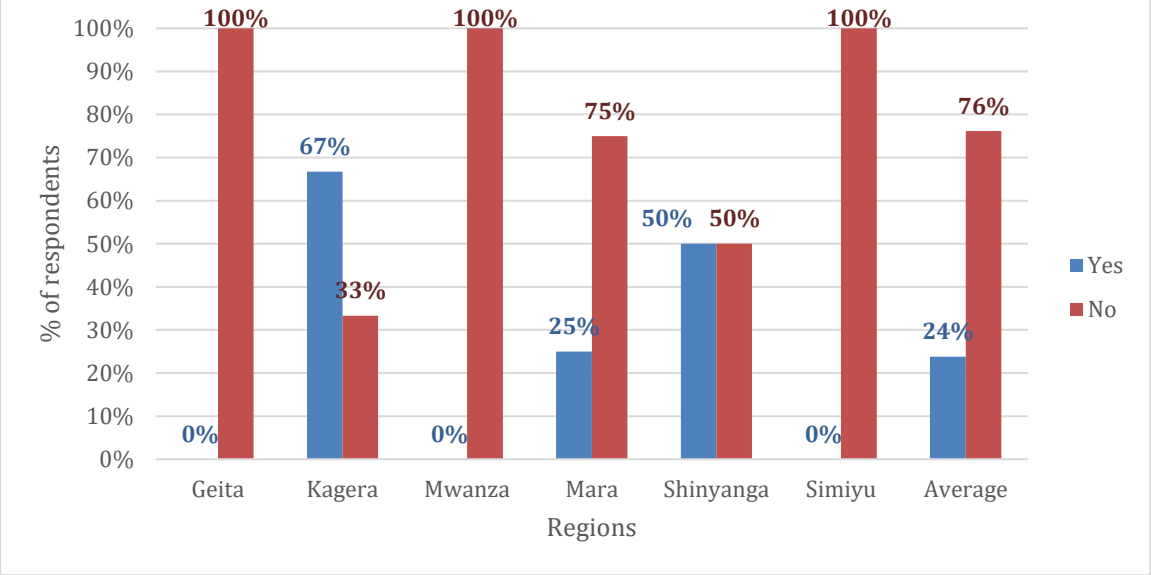
1.6 **Trained R/CHMTs currently conducting SS & M**

100% of the trained R/CHMTs are conducting SS. 85% of the trained R/CHMTs are conducting mentorship.

1.7 Sufficient numbers of staff to cover health facilities

The majority of respondents overwhelmingly responded “No” (100%) in four regions (Mwanza, Simiyu, Mara and Geita) when asked if R/CHMT/Facility staff trained are sufficient to ensure adequate training for others. Only Kagera responded with a positive trajectory of 66.7% and Shinyanga, 50%. *See Bar Chart 2.*

Figure 3: Bar chart showing % of respondents' assessment on whether the number of trained staff in supportive supervision in sufficient per region



1.8 Innovations on HMIS Use[8]

The additional columns (innovations introduced by Tibu Homa) are currently being used by Health Care facilities in the Lake Zone, supported by the Tibu Homa Program; four columns were added. The columns are assisting health facilities and their respective R/CHMTs to collect improved data on treatment of fever in children under 5 years of age (under-fives) in the following areas: under-fives presenting with fever; the period within which under-fives are being brought to Health Facilities (recommended in first 24 hours of fever sign); use of mRDT in diagnosis; and, identifying any under-fives as Orphans and Vulnerable Children (OVC). The collection of data and the use of data for decision-making purposes was viewed as an institutional weakness across most of the Ministry of Health primary health care facilities, in the Tibu Homa Program situational analysis[9], hence why a specific area of the program focused on Data Management as part of CM and SCM capacity-building.

The methodology chosen does not allow for direct attribution between training completed or data collected and a specific informed decision made about a patient's treatment, as a result. This is a more difficult causal relationship to prove in the absence of a clear review of medical files / records over a longer period of time than the allotted 14 working days. Instead, the methodology underscores the importance of Contribution Analysis [10] to this study. Qualitatively, Survey Tool 3, Question 1 helps us to make a stronger connection: *Qn1. In your opinion what are the three key things that your team/facility sees as the main gains in the following?*

[8] HMIS column use was also a feature of Survey Tool 3 (PQIT capacity). The respondents overwhelming answered with the same degree of positive support and enthusiasm for the addition of columns on under-fives presenting with fever; presence of OVCs; and presenting with fever within 24 hours.

[9] Tibu Homa Baseline Survey (January 2012).

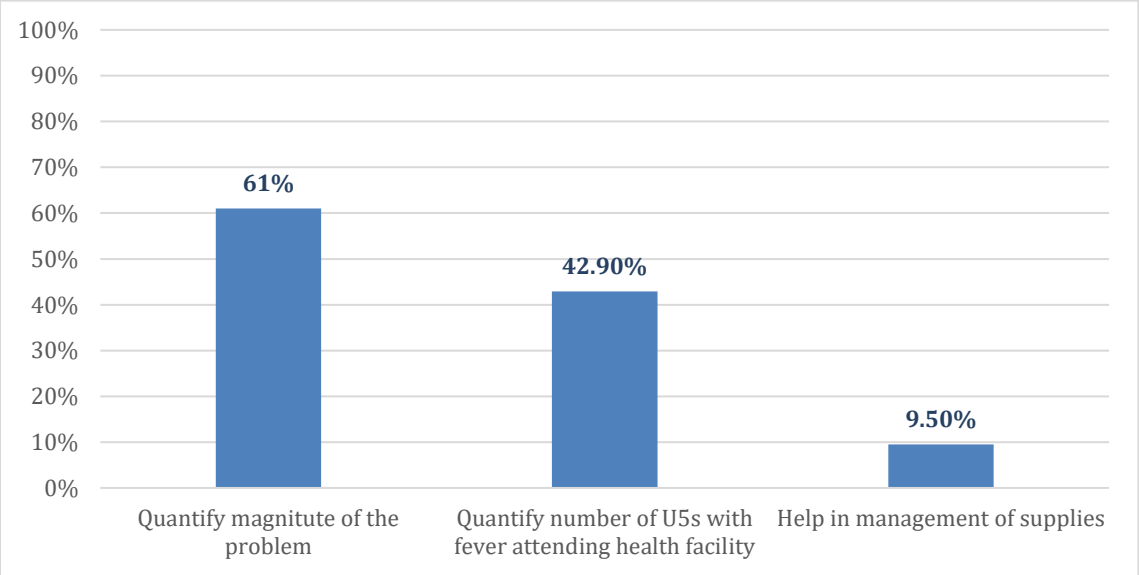
[10] Contribution analysis refers to developing a step-by-step chain of arguments to support a credible assertion that an intervention has (or has not) made a contribution, and possibly ranking the intervention among other contributions, to an intended outcome.

The answers provided demonstrate some evidence that Data Management is supporting better discussions on Case Management (CM) and Supply Chain Management (SCM) in facilities: Improved data use for decision-making (11/21 = 52%).

The column on mRDT is an innovation that has now been adopted by national health authorities across the region in part as a result of the advocacy of development partners who have been working in this area including the Walter Reed Society and the USAID-supported Tibu Homa Program.

The majority of respondents have felt the addition of the columns useful in understanding the magnitude of the problem of under-fives experiencing fever; parents and caretakers' response time in bringing a sick child to a facility; comparing diagnosis provided by mRDT with actual treatment given; and helping to link under-fives OVCs with other social services in the community. One of the main themes identified as "useful changes" by R/CHMT staff are noted below.

Figure 4: Bar chart showing respondents' perception on how useful the changes in HMIS register a column on under-fives with fever



1.9 Sustaining HMIS innovations

The key responses provided by surveyed R/CHMTs: ensure continuous training and monitoring of HCWs in the collection of the noted column data, their proper recording, and the required analysis to inform decision-making; and, ensure that SS &M is included as an item in the CCHP budget. The study highlights this as an area for future follow-up with the MoHSW to ensure that the columns—which have proved useful as per survey results—should be added formally to HMIS.

1.10 Overall Analysis of R/CHMT Management and Accountability

A key objective of this portion of the assessment is to ascertain the capacity of R/CHMTs in areas related to management and accountability. Four key areas have been identified by Tibu Homa Program staff. The criteria of capacity as defined for the purposes of the assessment are:

- Leadership and governance
- Financial management
- Trained human resources

- Appropriate/good facility level data collection/use

The survey results indicate that Tibu Homa-supported training has influenced R/CHMTs commitment to improve CM in their facility network hence demonstrating improved **leadership and governance.** The range of improvements demonstrate that R/CHMTs have integrated various components of skills and knowledge acquired through training into their work. Some of the key changes of note in both facility networks are:

a. *Adopted Tibu Homa Program mentorship tools during SS & M visit to Health Facilities including those not supported by Tibu Homa Program;*
b. *Ensuring health facilities keep, analyze and use data collected; look at the new chart and ask what fluctuation if any; more follow up by RHMT;*
c. *In supportive supervision, the RHMT is using clinical mentors to follow up and implements at the facility level in CM;*
d. *Improved communication between health facility and District Medical Office; improved availability of medicine at facility level; and*
e. *RHMT has disseminated guideline for CM and new IMCI guideline to support management of malaria; continuing with SS to CHMTs and district hospitals*

The Management and Accountability Survey (Tool 1), probed on how SS &M have contributed to improvements in R/CHMT capacity. Some ***89.5 % of RHMT respondents said that "Yes",*** changes have occurred to their approach on Supportive Supervision as a result of Tibu Homa training. Meanwhile, ***only 11.5% of respondents replied "No", that changes have not occurred as a result of training***. Some key modifications among RHMTs in the way they handle SS & M include: shifting from a culture of inspection to supervision; ensuring appropriate indicators track progress; more regular frequency of SS visits with follow up mentorship as required; capturing more data during Supportive Supervision and ensuring its proper logging in the Integrated Logistics System (ILS).

Within the CHMT structure improvements were also cited, notably: clearer roles and responsibilities for individuals providing SS and divided along functional lines; scope of work more focused; performing case review more frequently and, discussing gaps with Performance Quality Improvement Teams (PQITs).*See annex for full list of answers provided*.

RHMTs in the three original Tibu Homa regions (Mwanza, Mara and Kagera) benefitted from ***Implementation Progress Meetings*** which were opportunities for the R/CHMT officials to involve Regional Administrative Secretaries (RAS) and other local government authorities and advocate/lobby for support for health budgets and related programming. These Implementation Progress Meetings were held four (4) times during the course of the 5-year program. Action points were agreed upon after each of the implementation progress workshops. The last round of meetings was held in September 2014. The theory was that action points would help guide some concrete follow-up between and among the parties. From the 19 respondents: 9 answered "Yes", action points were agreed upon; 3 answered No, none were agreed upon; and 7 answered Not Applicable as many had not participated in these sessions. No Implementation Progress meetings were held in the three spread regions: Shinyanga, Simiyu and Geita.

Of the action points noted some degree of follow-up occurred on as follows:

a. *Advocacy to other sources of financing to leaders RAS, District Councils;*
b. *Medicine audit introduced and improved medical supplies;*
c. *Nearly all health facilities opened bank accounts; however, they don't know what to do with funds available;*
d. *Availability of medicine and supplies has improved;*
e. *Improving health-seeking behavior within 24 hours of onset of fever; and,*
f. *Increase in membership to Community Health Funds (increase from 4% to 36%).*

The survey reveals a key weakness in overall R/CHMT management capacity: **financial management and resource mobilization.** This training was only conducted with three RHMTs and fifteen CHMTs and was discontinued to the rest of the remaining regions/ districts due to Tibu Homa budget cuts effective November 2014. Hence, the survey results are not strong due, in part, to the lower number of individuals who actually received training in these areas compared to training in CM or SCM. However, in spite of lower numbers trained, the theory of change pursued the angle that training in financial management / resource mobilization may lead to opportunities to seek out other funding resources in the community/district in order to meet recurrent gaps. See Annex for Survey tools.

2 . Sustainability of Gains made by R/CHMT and PQITs

2.1 Survey Background

This portion of the survey was designed to assess and document the extent to which gains made to date are being sustained by the R/CHMTs and PQITs within health facilities. Sustainability is defined as: *holding the gains made and evolving as required without going back to the old way of doing things.*

The assessment will look into the contribution of R/CHMTs' capacity and functionality of PQITs as key contributors to sustaining gains made and will identify other variables that might have enhanced or limited the sustainability of gains made.

2.2 Challenges of the assessment

The portion of this assessment draws heavily from qualitative findings provided by survey respondents themselves. One survey was focused on R/CHMT members and a second, on PQITs within health care facilities. On average, two to four people were interviewed for the survey at each RHMT, CHMT or PQIT identified. Twenty-one (21) responses (from RHMT and CHMT members) and 14 responses (from PQIT members) were analyzed. Among PQIT respondents, four (4) were women. A roll-up of the analysis is provided indicating the number of respondents, that touched on this theme and the percentage (%) it represents of occurrence. Recall, that the total number does not add up to 100% as the questions were open-ended and hence each respondent could give as much or as little information as desired touching on one or possibly all of the key themes identified. The gains made in three key areas of Tibu Homa Program work are noted below under Case Management, Supply Chain Management and Data Management.

2.3 Analysis

R/CHMT and PQIT members noted the same key gain in Case Management: use of IMCI guidelines (71% among R/CHMT members; 57% among PQIT members). In Supply Chain Management: improved availability of medicines (81% among R/CHMT members; 50% among PQIT members). In Data Management: key gain noted is improved documentation (76% among R/CHMT members; 57 % among PQIT members).

The gains noted are consistent with other data provided in the other areas of the assessment hence this offers a strong predilection of the improvements that will remain in place beyond the life of Tibu Homa Program. And where, as required, and other funding sources are available, attention must be given to weaker areas of performance, primarily those in resource mobilization and community engagement.

The improvements noted by surveyed individuals on SS &M with THP support are key to sustaining gains. Under Supportive Supervision: increased frequency of occurrence, clearer definition of roles, and better tools now applied. Under Mentorship: attitude of mentors is now

more open, positive and supportive towards HCWs, clear roles defined and mentorship is now integrated into SS visits.[11]

The challenges and plans section below indicate a common experience of the challenges and some diversion in plans around Case Management, Supply Chain Management and Data Management among R/CHMTs and PQITs*. See Figure 5: Main Gains by Institution and Type.* In the best case scenario -- 2A -- represents a good example of when the information collected clearly indicates a "challenge" to a desired situation and a potential "plan" to meet that challenge. A number of the respondents provided "stock out of mRDTs" as a key challenge to under-fives having access to mRDTs/microscopy as part of the diagnostic piece of treatment puzzle. The plan provided (by both R/CHMT and PQIT) are clearly linked to address the challenges identified: increased communications among relevant parties engaged in supply chain management and internal use of tools to support tracking of facility supplies. Under PQIT's, the perceived plan to address "stock-out of mRDTs" is to shift to microscopy. The "challenge-plan" approach is helpful in triangulating data in other sections of the survey. *See Figure 6: Challenges and Plans Comparison by theme.*

The theory is to ensure that R/CHMTs and PQITs are able to distinguish and identify the challenges and highlight what efforts need to be in place to meet them. Where R/CHMTs or PQITs were unable to clearly provide the information, this is indicative of either a poor understanding of its relevance to treatment of under-fives with fever or that the respondents may not have the problem identification and problem solving skills required.

The weakest area with respect to gains made is in the area of financial management and resource mobilization. Financial management training took place in three regions however the weakness arises in the follow-up to training; action points and marketing plans were not implemented after trainings. See *Q-2: Has training in financial management resulted in the implementation of action plans?) And QN5. Has your R/CHMT sought any support from partners for the past one year?* There appears to be more sustainable potential in the area of mobilizing around use of Community Health Funds (CHF) as noted under R/CHMT Management and Accountability survey questions*: Qn3. Has your R/CHMT conducted any CHF strengthening interventions?* The CHF is seen as a means to help supplement recurrent costs in health care facilities. Beyond that method, there appears to be some isolated examples of health care facilities reaching out to work with other partners (8/20 surveyed), however, this still represents less than half of overall respondents.

[11] From Survey Tool 2 (R/CHMT capacity only).

2.4 Survey Results: *Key Gains Made*

Figure 5: Main Gains cited by institution and type

R/CHMT (21 respondents)	PQIT (14 respondents)
Case management	
Main themes:	***Main themes:***
Improved use of IMCI guidelines (15/21=71.4%)	Prioritizing treatment of under-fives leading to better health outcomes (6/14 = 42 %)
Rational use of anti-malaria medicine (4/21=19.1%)	Improved use of IMCI guidelines (8/14 = 57 %)
	Rational use of anti-malaria medicine (3/14 = 21 %)
Supply Chain Management	
Main themes:	***Main themes:***
Improved availability of medicines (17/21=81%)	Improved availability of medicines (7/14= 50%)
Improved use of ILS tools (8/21=38.1%)	Improved use of data-collection tools (2/14= 14 %)
	Reduced wastage/improved decision-making regarding stocks (2/14 = 14 %)
Data Management	
Main themes:	***Main themes:***
Improved documentation (16/21 = 76%)	Improved documentation (8/14 = 57%)
Improved data use for decision-making (11/21 = 52%)	
Improved awareness among health care workers of their roles in supporting data management (7/21 = 33 %)	

2.5 Key Challenges identified by R/CHMT and PQIT personnel and plans to address them

i. Under-fives with fever getting mRDT/microscopy testing

Analysis

A correct diagnosis using appropriate techniques is the first important step in putting an under-five child on an appropriate treatment plan. The Tibu Homa Program has been working to turn around an entrenched pattern of "presumptive diagnosis and management of febrile illness" among the health care facilities in Tanzania into a system where rapid diagnostic tests play a central role, increasing correct diagnosis and treatment. The 2010 Tanzania Demographic Health Survey also found that only 16% of children with fever in the two weeks preceding the survey received an mRDT[12] with improvements in the testing rates (by use of mRDT) to approximately 55% in 2013[13] . The mRDT is a new diagnostic kit (introduced in

[12] The Tanzania Demographic Health Survey (TDHS, 2010)

[13] Tanzania makes progress in the fight against Malaria, retrieved from http://www.ippmedia.com/frontend/?l=55648

2010) and hence, is still viewed with some suspicion and a fundamental misunderstanding among HCWs. Meanwhile, the microscopy has been the default diagnostic test up until the arrival of mRDT, where facilities exist.

The plan points provided are clearly linked to address the challenges identified: increased communications among relevant parties engaged in supply chain management (to ensure diagnostic materials available) and internal use of tools to support tracking of facility supplies. Meanwhile, the issue of HCWs training—raised as a challenge—will help to ensure more Health Facilities properly employ and trust the mRDT in the future as a low-cost and reliable diagnostic kit to assess presence of malaria in children under five.

Figure 6: Challenges and plans comparison by theme

Assessed Area: (A) Under-fives with fever getting mRDT/microscopy testing	
Main Challenge (RHMT)	**Main Plan (to address)**
➢ Stock out of MRDTs ➢ Training on the use of MRDTs	➢ Increase communication between MSDs, CHMTs, RHMTs and health facilities ➢ Increased use of ILS tools and forms ➢ Training of health care workers on the use of MRDTs
Main Challenge (PQIT)	**Main Plan (to address) PQIT**
➢ Stock out of MRDTs	➢ Use microscopy ➢ Strengthen communication among partners

ii. Compliance to IMCI algorithm

Analysis

The compliance to IMCI algorithm is an important element of improved Case Management skill set. The following challenges are related to untrained or too few human resources. The proposed "plan" to address is related and relevant to the theme raised. The IMCI algorithm is a multi-stage process that includes all elements of treatment from diagnosis to potential treatment options making the issue of Supply Chain Management (as indicated as a theme, relevant).

Assessed Area: (B) Compliance to IMCI algorithm	
Main Challenge (R/CHMT)	**Main Plan (to address) (R/CHMT)**
➢ Readiness to change ➢ Shortage of staff ➢ Lack of training and awareness ➢ Stock out of medicines and a lack of essential supplies	➢ Mentoring and training of Health Care Workers (HCW) ➢ Forming PQITs ➢ Budgeting for required resources i.e. human and supply (Basket Fund and CCHP)
Main Challenge (PQIT)	**Main Plan (to address) (PQIT)**
➢ Clinician workload (too many patients, guidelines seen as time-consuming)	➢ Continue On the Job training ➢ Conduct case reviews

iii. Treatment of under-fives by a skilled provider within 24-hr of onset of fever

Analysis

The question looks to identify the issue of both access to "skilled" health care providers but also the question of whether children are being brought to the clinic within the important 24-hr fever onset window of diagnosis. The key themes are noted below. However, overwhelmingly, the key barrier is parents' delay related to the lack of awareness in bringing their children to health care facilities within the necessary time frame. This practice is compounded by a lack

of information and health education being provided by health care workers to underscore the importance of bringing under-five children to seek help as soon as a fever is detected. In addition, distance from health facilities also inhibits parents' reaching health facilities quickly. Meanwhile, the continued use of traditional healers over the health care system provided a dis-incentive to seek help from a skilled provider as soon as possible, as, it appears, in rural areas, traditional healers still hold a great degree of sway and influence over parental decisions. These are common challenges as perceived by both PQIT and R/CHMT staff.

The other noted challenge in providing treatment by a skilled provider is the inadequacy of skilled staff perhaps caused by lack of training opportunities and/or inadequate use of medicines and supplies.

The R/CHMTs and PQITs provide adequate plans to address the key themes from the provision of health education to parents, supportive supervision and mentorship to benefit HCWs, and ensuring the adequate availability of training funds through appropriate budgeting.

Assessed Area: (C) Treatment of UNDER-FIVESs by a skilled provider within 24-hr of onset of fever	
Main Challenges (R/CHMT)	**Main Plan (to address) (R/CHMT)**
➢ Parents delay ➢ Lack of information from healthcare workers ➢ Lack of awareness ➢ Distance form health facilities ➢ Inadequate skilled staff ➢ Use of traditional healers	➢ Health education to parents ➢ SS and mentorship to Health care workers ➢ Budgeting for it
Main Challenges (PQIT)	**Main Plan (to address) (PQIT)**
➢ Parents delay ➢ Use of traditional healers ➢ Distance from health facilities	➢ Health education to parents ➢ SS and mentorship to Health care workers

iv. Correct Treatment for uncomplicated malaria

Analysis

The question probes the understanding of R/CHMTs of "*correct*" vs. "*not correct*" treatment for uncomplicated malaria. Correct procedures refers to the different stages of "treatment" from: *Case Management (CM); Supply Chain Management (SCM); and Data Management.* Some of the main challenges cited arising from "correct" treatment underscore issues around lack of training of HCWs (knowledge/ trust associated with mRDT results, and, not following Ministry of Health-approved IMCI guidelines). Another key challenge cited was frequent shortages of drugs and supplies. The R/CHMTs cited appropriate plans to counter some of these key challenges: training and mentorship; ensuring adequate supply (presumably with enhanced Supply Chain Management and Data Management techniques and overall training), and enhanced communications among relevant partners to ensure no missed opportunities for collaboration around ensuring adequate supplies and medicines in stock. On the PQIT side, a new challenge was noted, that many patients arrive in the late stages of malaria onset making the treatment "complicated."

Assessed Area: (D) Correct Treatment for uncomplicated malaria	
Main Challenges (R/CHMT)	**Main Plan (to address) (R/CHMT)**

➢ Health care workers do not trust MRDT results ➢ Not following IMCI guidelines ➢ Stock out of drugs and supply	➢ Ensuring adequate supply ➢ Communication among relevant partners (MSD, health facilities, etc.) ➢ Training and mentorship
Main Challenges (PQIT)	**Main Plan (to address) (PQIT)**
➢ Stock out of drugs and supply ➢ Patients arrive too late making it "complicated malaria" treatment	➢ Ensuring adequate supply ➢ Communication among relevant partners (MSD, health facilities, District Pharmacist etc.)

v. Availability of ACTs and mRDT at facility level

Analysis

The respondents overwhelmingly noted the trend of stock out of supplies which contributes to availability of anti-malarial medicines (ACTs) and the rapid diagnostic kits known as "mRDT" at health care facilities. The plan focuses on mentorship and training within SCM and in strengthening communication among partners.

Assessed Area: (E) Availability of ALU and mRDT at facility level	
Main Challenges (R/CHMT)	**Main Plan (to address) (R/CHMT)**
➢ Stock outs	➢ Strengthening communication among partners ➢ Mentorship and training in SCM
Main Challenges (PQIT)	**Main Plan (to address) (PQIT)**
➢ Occasional stock outs	➢ Use of microscopy when MRDT out of stock ➢ Strengthening communication among partners

vi. Availability of under-fives' patient cards and other data collection tools

Analysis

The respondents provided the same response under challenges noting that the majority of health facilities still use exercise books for record-keeping. Based on Tibu Homa team observation coupled with survey results, most of the facilities still allow parents to come and go with the school exercise book as health record book rather than leaving them within the facilities' Records Management Unit (RMU). The other major response noted was that the "supply" of patient cards is not the identified challenge or problem instead it is the choice of whether or not to use them. Some provided responses to help illuminate: "*Exercise books are still used for record keeping,"* and, *"Still some facilities are using exercise books,"* and, others highlighted *"No problem, currently in Musoma Rural, "* and *"No problem, cards are available."*

Patient cards and other data collection tools are available however the habit of using them does not yet appear strong. The most often-proposed plan to address this challenge appears to be to integrate data collection needs, the availability of patient cards, and most importantly, the supervision and mentorship required to apply and use them properly, into the budgets of the Comprehensive Council Health Plans (CCHP).

Assessed Area: (F) Availability of UNDER-FIVESs' patient cards and other data collection tools	
Main Challenges (R/CHMT)	**Main Plan (to address) (R/CHMT)**
Exercise books are still used for record keeping No problem with supply of cards	➢ Budgeting for it in Comprehensive Council Health Plan (CCHP)
Main Challenges (PQIT)	**Main Plan (to address) (PQIT)**
➢ Exercise books are still used for record keeping ➢ No problem with supply of cards	➢ None needed to address. ➢ Budget for cards/files in CCHP.

vii. Collection and use of data at facility level

Analysis
This survey question helps to triangulate findings from the first question in Survey Tool 3: What are the key gains for Data Management? Data management is key to enhanced CM and a cornerstone of the PQIT work—to ensure facility managers are encouraging data collection and data use as part of their decision-making around issues of quality of health care arising in the treatment of under 5 children presenting with fever, specifically related to this program, and also within the broader clientele population.

The key challenges are noted above and were succinctly noted by the vast majority of respondents: the cadre of HCWs still lack essential knowledge and skill related to data collection and use. The R/CHMT's key theme or plan to address this recurrent challenge is clearly focused on enhanced opportunities, budget for Supportive Supervision (SS) and mentorship, and the PQITs suggest appointing a data collection focal person who can help mentor/lead efforts.

Assessed Area: (G) Collection and use of data at facility level	
Main Challenges (R/CHMT)	**Main Plan (to address) (R/CHMT)**
➢ Insufficient knowledge on data collection and use ➢ Limited system capabilities	➢ Mentorship
Main Challenges (PQIT)	**Main Plan (to address) (PQIT)**
➢ Insufficient knowledge on data collection and use ➢ Incomplete data	➢ Mentorship, regular meeting of PQITs ➢ Assign data focal person

viii. Policy suggestions to improve case management
A range of responses was provided that underscore some original and some unanticipated responses in this area. A recurring theme is the desire to ensure ongoing technical supervision of HCWs and mentorship of existing guidelines around mRDT / IMCI. They include: support for a biannual case management review and ongoing performance evaluations.

ix. Resource Mobilization

Analysis
This question underscores the motivation factor of R/CHMTs in reaching out to find support for programming funds, from other sources, i.e. to use their ideas to help support filling gaps. Of those surveyed, 40% responded that they had reached out to other sources for support

meanwhile 50% had not or the issue did not apply to them. Some of the identified partners', illustrate an interesting cross-section of approaches/- partnerships. The majority are existing non-governmental/international organizations currently working in Tanzania on like-minded areas of programming to Tibu Homa, or those that are already working within the Lake Zone. The list of partners and the type of support provided demonstrates that while some R/CHMTs have reached out, this is not the norm, and that the shared understanding of partnerships beyond government extend to international NGOs only and not to potential other sources, i.e. within private sector or the broader national community. The support provided ranges from support for quality control of mRDT testing to acquiring a vehicle to assist with Supportive Supervision visits in outlying areas. [14]

As for PQIT members surveyed, the vast majority feel they are supported by health care facility management, either at the District or Regional level. The type of support provided ranges from photocopying of report templates, stationary, facilitation of team meetings and case reviews, ongoing on-the-job training.

3. Assessment of the PQITs Functionality

3.1. Survey Background

To enable documentation of key issues, a supportive supervision checklist is routinely used to assess functionality of the PQITs. This checklist was adapted and used for the assessment purposes to obtain quantitative information. The checklist was adapted to include a section on the availability of medicines and supplies for evidence of stock out. The identified key issues for PQITs were grouped into five building blocks of health systems (stipulated by WHO) and these includes:

1. PQIT leadership
2. Availability of essential medicines and medical products/equipment
3. Health Information Management System (HIMS)
4. Human Resources for Health
5. Health service organization and delivery

3.2. Survey Results

3.2.1 Leadership

Analysis

In the six (6) areas noted under this section, most assessments highlighted positive trends in 5/6 observed areas of PQIT leadership. The area of interest that showed negative trends were related to the holding of *regularly scheduled team meetings* and the team sharing of *implementation results with Health Management Team (HMT) and the rest of HCWs".*

Although leadership appears to be functioning because the PQIT roles and responsibilities have been defined and assigned there are some challenges:

- Variation occurs in the regularity of scheduled team meetings (Kagera 72%, Mara 63% and Mwanza 41%)
- The preparation of follow-up minutes is erratic appearing only as a strong tendency in Kagera (71%)
- Follow-up action points deliberated upon is not systematic -only Kagera reports a 58% follow-up rate compared to no follow up in either Shinyanga (82%) or Simiyu (73%)

[14] See annex for full list of potential partners and resourced activities.

-
- Follow up of results-shared with the Health Management team and the rest of the HCWs cadre is erratic.

3.3 ***Availability of medicines and supplies***
See frequency tables in Annex 2. Most facilities have showed progress in keeping supply stocks above 10+ tracer items

3.4 Health Management Information System (HMIS)
Analysis

There is demonstrated improvement in the HMIS which supports overall efforts to improve data management. The enhanced availability and use of data should lead to enhanced data use for decision – making. While the data below does not show a direct correlation between enhanced data collection and more informed decisions on patient care, the potential for data use is much greater as a result of the combined efforts of Supportive Supervision and Mentorship in conjunction with enhanced data collection tools and knowledge of how to use the tools more appropriately. This is made more clear when looking at the information collected below—on Extra Column available—and cross referencing with the feedback provided under another portion of the Sustainability Assessment: QN 9 – Revisions to Health Management Information System (four new columns added in Tibu Homa supported health facilities). Shinyanga Region appears the weakest with respect to overall facilities noting supply challenges/use of outpatient cards (44%). Meanwhile, OPD files appear available denoting a large move to ensure health files are located on site at the facility and/or a greater degree of community awareness has occurred so that parents' bring the exercise book with them to their health care visit. A majority of health facilities (62%) noted IPD files were not available. Note that the overall number of health facilities are either dispensaries or health centers, the results are not surprising, given the mission of these facilities do not include inpatient services.

3.5 ***Health service organization and delivery***

Analysis

This segment provides a clear picture of the confluence of infrastructure factors, budget, and community infrastructure in support of the proper functioning of health facilities.

The assessment looked at a series of innovations that have been introduced and/or recommended by the Government of Tanzania (GoT) in various policy documents or guidelines. The program advocated for easy accessibility tor under five services, for example separate Out Patient Department (OPD) be formalized for children under-five years of age and a separate pediatric and neonatal wards (in hospitals) be established. However, mostly due to lack of resources or space, these are not attainable within current budgetary resources.

The five regions performed well in areas of basic necessities:

a. *Functioning and clean toilet*
b. *Reliable source of water; good in Mara (67.5%) and Kagera (81%) but generally reaching only 50% accessible levels in Mwanza, Shinyanga and Simiyu*
c. *Reliable source of power*
d. *Adequate facilities for waste disposal; Mwanza and Simiyu slightly worse but still acceptable*
e. *Triage system in place; all regions reporting system in place above 70% with exception of Simiyu facilities (47%)*
f. *Guidelines are available; all reporting above 95%*
g. *Reliable system for referrals; Mwanza (55%) and Shinyanga (53%) of facilities report a referral system in place*

Where there was more general inability to reach these items, it was related to separate consultation and dispensing rooms. Declaration of N/A indicated the specific item is not applicable at that level of service, for example, dispensaries do not cater to in-patients nor do they provide acute pediatric care.

IV. Conclusions

Overall, the Sustainability Assessment has reached some well-founded conclusions about the Tibu Homa Program's efforts. They include:

1. Health Managers who were trained, report they are conducting Supportive Supervision and Mentorship on a regular basis. This is a good sign that Case Management improvements will be sustained. However, the percentage of facilities covered / reached through these visits remains quite low. This is an ongoing issue of concern about expanding the reach of supportive supervision to ensure more health care workers benefit around the three key areas of Tibu Homa work. This begs the question on prioritization of activities of health managers—are they planning Supportive Supervision and Mentorship into their annual work plans and budgets—or simply coasting on the back of Tibu Homa prodding?

2. Health Managers appear to care about the training of Health Care Workers however there appears to be little effort to ensure that funds are allocated for this purpose. The efforts to mobilize resources to cover these recurrent costs appears weak and limited at best in some key areas. The evidence shows that this is still too much dependent on individuals' will as opposed to institutional knowledge and culture. Resource mobilization will continue to be a weak area and will require more follow up and support.

3. The addition of data columns in the HIMS (commonly known as MTUHA in Swahili) in Tibu Homa-supported facilities was viewed as a positive and useful step among surveyed R/CHMT and PQITs. The new columns are dedicated to collecting data around the treatment and care of children under five years of age presenting with fever to build a better body of knowledge and information to improve diagnosis and treatment. The vast majority of respondents view this information as supportive of their work. However, a weakness of the assessment is that no strong quantitative evidence exists showing a direct link between *information collected* and *decisions made* about care of Under Five (5) children.

4. The follow up from Financial Management and Resource Mobilization training appears weak and intermittent. This underscores a management weakness and poor accountability at Council and Regional levels; managers do not see, as part of their responsibilities, the need to encourage staff to think "outside the box" on resource mobilization, nor are there any mechanisms in place within the Regional or Council frameworks to ensure work is done in these areas. The Tibu Homa Program cannot discipline the authorities on these points.

5. There are inadequate data recording tools and a corresponding lack of culture in using the tools. This will require ongoing and specific mentorship to ensure gains made in case management and availability of medicines and supplies are not lost.

6. R/CHMTs and PQITS clearly value the availability and use of IMCI guidelines, improved availability of medicines, and improved documentation of data to improve case management.

7. The relationship between PQITs and the Facility management is not as yet conducive to the exchange and sharing of the PQIT experiences on a regular basis

V. Recommendations

Based on the conclusions, some key follow-ups are recommended for consideration by Ministry of Health and Social Welfare (MoHSW) officials in order to maximize chances for broader sustainability.

1. Health managers at the Regional Medical Officers/District Medical Officers should apportion a specific percentage of their time for conducting and training in Supportive Supervision and Mentorship as this method appears the best to ensure gains are not lost. They should focus on applying skills learned under the Tibu Homa Program, i.e. ensuring the combination of staff with clinical, supply chain and data management skills expertise on the supportive supervision and mentorship team.

2. Continue efforts to build the capacity of RHMTs in mobilizing resources. A specific training item in this area should be integrated into the Comprehensive Council Health Plans. There are a number of potential private-public partnerships that could be forged however health care authorities are tepid at best in initiating thinking on these due to lack of knowledge and / or lack of motivation in seeing this as an integral part of their jobs.

3. Mobilize and expand information-sharing of good practices of Community Health Fund sensitization campaigns in order for other districts to learn from these efforts, in particular, so experiences of increased membership numbers can be seen as an opportunity to ensure other funding opportunities to cover recurrent costs.

4. Advocate to Ministry of Health and Social Welfare (MOHSW) the inclusion of additional data columns in Health Management Information System (HMIS) based on the positive feedback from Tibu Homa assessment. The information generated will support enhanced efforts to treat/diagnose children under five (under-fives). This cannot be attributed only to Tibu Homa work but to other organizations including Walter Reed Society.

5. Promote and highlight the efforts of health care workers who are role models in improving Supply Chain Management and Data Management. Explore a MOHSW – wide venue for bringing positive attention to their efforts, perhaps as a special recognition, a certificate for these efforts or enhanced follow up training and designation of these people as “trainers” who might eventually benefit from an annual training bonus if they share their knowledge/skills with others.

   R/CHMTs should prioritize on monitoring of the availability and use of IMCI guidelines; stock levels of medicines and supplies; collection and use of data-as key components of supportive supervision and mentorship.

6.0 Annexes

Annex 1: Survey Tools (1, 2 and 3).

Survey Instrument 1: Capacity of R/CHMTs

A. Case Management

1. What is the current number of members of the R/CHMT? How many of the members are trained in SS & mentorship?

	Total number of members	Number trained in SS	Number trained in mentorship
RHMT			
CHMT			

2. Are the trained R/CHMTs currently conducting supportive supervision and mentorship?

Supportive supervision		Mentorship	
Yes	No	Yes	No

If yes, when was the last SS and mentorship conducted?

3. How frequent was supportive supervision and mentorship conducted in the last 6 months?

Once a month	Once every two months	Once a quarter	Other) specify)

4. What percent of Health Facilities did you manage to reach?

5. Are the R/CHMT members trained in SS and mentorship sufficient to cover health facilities in the region/ District??

Yes	No

If NO, What is the real number needed to provide SS and mentorship?

6. How many of your R/CHMTs members are trained in updated IMCI guidelines (2012)?

7. Does the R/CHMT have plans to train HCWs in case management without THP support? If so when? Ask to see the plan. If NO ask why not?

	Yes has a plan to train	Plan seen	Plan not seen	No has no plan to train
RHMT				
CHMT				

8. Reason for not planning to train HCWs in case management:

9. Regarding innovations made in MTUHA

What have you found useful about the changes?

	Changes	How useful
R/CHMTs	Column on under-fives presenting with fever	
	Column on under-fives presenting with fever within 24 hrs	
	Column on mRDT	
	Column on OVC	

10. How will you support facilities sustain these innovations?

B. Management and accountability

1. What changes have been made in R/CHMT management to improve CM at facility level? List two to three.

For those trained in SS & mentorship:

2. Has this changed the way you conduct SS?

If yes, how?

	Yes changed the way I contact SS and mentorship	No did not change the way I contact SS and mentorship	Ways in which it has changed the way I contact SS and Mentorship)(list 2 to 3)
RHMT			
CHMT			

3. **FOR R/CHMTs THAT PARTICIPATED IN IMPLEMENTATION PROGRESS MEETINGS:** Has the R/CHMT implemented any action points agreed upon from implementation progress meetings held during project implementation period? Please list the action points acted upon?

Yes	No
Action points Implemented 1. 2. 3.	

C. Resource mobilization

1. FOR R/CHMTs TRAINED IN FM: How many R/CHMT members trained in the financial management have implemented their marketing plans developed during training?

2. Has your CHMT secured funding as a result of implementing your marketing plans (from sources other than GoT)
   If yes, what were the funds used for?

3. Has your R/CHMT conducted any CHF strengthening interventions? Can you name them

Survey Instrument 2: Sustainability of gains-R/CHMTs

1. In your opinion what are the three key things that your team/facility sees as the main gains in the following;

    a. Case management

    b. Supply Chain Management

    c. Data management

2. What challenges have you had in improving the following and how are you addressing the challenges?

	Indicator	Challenge(s) encountered	How addressed/ plans to address
a.	Under-fives with fever getting mRDT/microscopy testing		
b.	Compliance to IMCI algorithm		

c.	Treatment of UNDER-FIVESs by a skilled provider within 24 hrs of onset of fever		
d.	Correct Treatment for uncomplicated malaria		
e.	Availability of Alu and mRDT at facility level		
f.	Availability of UNDER-FIVESs' patient cards and other data collection tools		
g.	Collection and use of data at facility level		

3. What are the key differences in the way;
   a. Supportive supervision was conducted before the Tibu Homa project and now

   b. Mentorship was conducted before the Tibu Homa project and now

4. What policy changes do R/CHMTs see as necessary to improve case management at the facility level?

5. Has your R/CHMT sought any support from partners for the past one year? If yes, what partner and what support?

Survey Instrument 3: Sustainability of Gains made by facilities - PQITs

Gains made in Case Management

1. In your opinion what are the three key things that your team/facility sees as the main gains in CM, SCM and data management?

1	
2	
3	
Other	

2. What challenges have you had in improving the following and how are you addressing the challenges?

	Indicator	Challenge(s) encountered	How addressed/ plans to address
a.	Under-fives with fever getting mRDT/microscopy testing		
b.	Compliance to IMCI algorithm		
c.	Treatment of UNDER-FIVESs by a skilled provider within 24 hrs of onset of fever		
d.	Correct Treatment for uncomplicated malaria		
e.	Availability of Alu and mRDT at facility level		

f.	Availability of UNDER-FIVESs' patient cards and other data collection tools		
g.	Collection and use of data at facility level		

3. Is the R/CHMT providing you with SS without THP support?

Yes	No

If so: when was the last visit?

If not why not?

4. Are the R/CHMTs providing you with mentorship in CM at facility level??

Yes	No

If so: when was the last visit

If not why not?

Please describe two to three changes that have occurred to improve data use and management.

1.   2.   3 .

4. Regarding innovations made in MTUHA, what have you found useful about the changes?

changes	How useful
Column on under five presenting with fever	
Column on under five presenting with fever within 24 hours	
Column on mRDT	
Column on OVC	

Gains made in SCM

1. Are the R/CHMTs providing you with mentorship in logistics at facility level??

Yes	No

If so: when was the last visit

If not why not?

In what ways did logistics mentorship help improve the availability of medicines and supplies?

2. Please describe improvements if any in communication between your facility and the DMO's office/MSD in regard to improving SCM at the facility level?

How will you maintain this without THP support?

3. Is the health facility receiving Malaria Rapid Diagnostic tests and ACTs from MSD regularly? Will the regular supply continue after THP?

Yes receiving		No not receiving		Yes will continue to receive after THP		No will not continue to receive after THP
mRDT kits	Anti-malarial drugs (ALu)	mRDT kits	Anti-malarials (ALu)	mRDT	Anti-malarials (ALu)	

i. If they will not continue to receive ask why not?

4. How have Medicines and Therapeutic Committees contributed to improving the availability of supplies?

Gains made in Community mobilization

For facilities outside the community mobilization districts:

1. Have you received under-fives with fever referred to you by CHWs, TBAs, or VHC?

	Yes	No
Health Facility type: 1. Hospital 2. Health center 3. Dispensary		

If yes, did your facility provide feedback to the CHWs/VHC/TBA? In what form?

2. Do you know if locally organized groups in your community include discussion on fever in under-fives and OVCs in their regular meetings?

	Yes	No
Health Facility type 1. Hospital 2. Health center 3. Dispensary		

In those communities with organized community groups: What changes have seen that these groups have made in helping under-fives and OVCs access services?

3. Does your Health facility have IMCI guidelines/job aids?

	Yes	No
Health Facility type 1. Hospital 2. Health center 3. Dispensary		

If no why not?

4. Is the facility management providing support to your PQIT?

Circle type of facility	Yes	No
Health Facility type: 1. Hospital 2. Health Center 3. Dispensary		

If yes, what kind of support?

Do you feel this is sustainable?

	Yes	No
Health Facility type 1. Hospital 2. Health Center 3. Dispensary		

5. Is the facility testing and identifying successful interventions to improve case management of febrile illness in under-fives.

	Yes	No
Health Facility type:		

1. Hospital 2. Health Center 3. Dispensary		

If yes how?

If not why not?

6. FOR FACILITY IN CHARGE: Has your health facility managed to raise any resources from private companies or donors other than MOHSW in the last year? Please name source.

	Yes	No	Source
Health Facility type: 1. Hospital 2. Health center 3. Dispensary			

Annex 2: Frequency Tables for SA and PQIT Assessment

PQIT Performance / Survey Tool 3/ Table depictions of key results

Availability of medicines/supplies

	Kagera		Mara		Mwanza		Shinyanga		Simiyu		Total	
# tracer medicines in stock on day of visit	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
10 +	39	95	40	976	64	98.5	47	100	43	98	233	979
4-9	2	5	1	2.4	1	1.5	0	0	1	2.3	5	2.1
0-4												
Total	41	100	41	100	65	100	47	100	44	100	238	100

Leadership complete?

	Kagera		Mara		Mwanza		Shinyanga		Simiyu		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
No	1	2.3	7	1	7	11%	13	28	16	36.4	44	18.5
N/A	0	0	3	7.3	6	9.5	0	0	0	0	9	4
Yes	42	98	31	76	51	79.5	33	72	28	64	185	78
Total	**43**	**100**	**41**	**100**	**64**	**100**	**46**	**100**	**44**	**100**	**238**	**100**

Health Management Information System

	Kagera		Mara		Mwanza		Shinyanga		Simiyu		Total	
HMIS indicator	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
OPD Cards (Yes)	28	63	35	89.	41	65	21	45	22	50	147/ 62%	71%
IPD files (Yes)[15] and N/A	15 (N/A 23)	34 (N/A 52)	17 (N/A 19)	4 (N/A 50)	21 (N/A 35)	33 (N/A 55)	3	6.4	3	6.8	59 (N/A 147)	37% (N/A 53%)
Extra Column Available (Yes)	43	98	33	89	57	89	46	98	36	84	215	92%
OPD Files Available (Yes)	43	98	32	87	50	78	33	70	28	63.7	186/ 79	86%

[15] In-patient files are not applicable in Dispensary/Health Centre settings, only in hospitals hence many respondents replied N/A and a few number of "Yes" which was the likely answer for hospital staff interviewed.

Human Resources for Health

	Kagera	Mwanza	Mara	Shinyanga	Simiyu	All regions
Total # observed	**44**	**65**	**40**	**46**	**44**	**239**
Average/Trained Staff in Case Management (CM)	1.6 (SD, 0.8)	3.1 (SD, 3.5)	1.9 (SD 1.5)	1.76 (SD 1.5)	2.05 (SD 1.24)	2.15 (SD 2.19)
Average/Skilled Provider	5.6 (SD 4.3)	8.6 (SD, 7.4)	5.6 (SD 2.9)	4.8 (SD 5)	5.16 (SD 6.7)	8.39 (SD 7.38)

Health Service Organization and delivery, overall results

Health service organization and delivery					**Total**
	No	**Yes**	**N/A**	**# Response**	**# facilities**
Separate OPD	192 (80.3. %)[16]	43		4	239
Separate Pediatric Ward	37	43	[17]157 (65.7%)	2	239
Separate Neonatal ward or room?	58	8	[18]166(69.5%)	4	239
Separate malnutrition ward or room?	62	8	166 (69.5%)	3	239
Separate infectious ward or room?	219 (92%)[19]	15		4	239
APCU/ICU	40	11	183 (76.6%)[20]	5	239

[16] Refers to all health facilities: 80.3 % of health facilities lack a separate OPD for children.
[17] Not applicable in dispensaries as they are not designed for in-patient services.
[18] Not applicable in dispensaries as they are not designed for in-patient services.
[19] Refers to hospitals. 92% do not have separate facilities for infectious disease.
[20] Not applicable in dispensaries as they are not designed for in-patient services.

Annex 3: Survey Tool 1 Other Key Results

This section includes other survey outcomes too numerous to feature in the body of the Sustainability Report. Note that most of the outcomes from Survey Tool 2 (Sustainable Gains) are integrated directly into the body of the report.

Frequency of SS and mentoring
12/17 responding R/CHMTs have returned a response rate of 70% undertaking SS and mentorship once a quarter. 4/17 reported once a month.

Coverage of health care facilities reached
Kagera (92%) and Mwanza (100%). The lowest number of health facilities reached in Geita (30%).

R/CMHT training in updated IMCI guidelines
Highest returns in Shinyanga, Simiyu (3 and 4 people trained respectively).

R/CHMT training plans for HCWs in case management
In many instances, R/CHMTs had a plan however funds were not available to follow through with planned training.
This highlights an ongoing concern that if regular funds are unavailable for training, R/CHMTs should consider alternative sources to support.

Innovations to the Health Management Information System (known as "MTUHA" in Swahili)
The additional columns (innovations introduced by Tibu Homa) are currently being used by Health Care facilities in the Lake Victoria Zone, supported by the Tibu Homa Program; four columns were added. The columns are assisting health facilities and their respective R/CHMTs to collect improved data on treatment of fever in children under 5 years of age (UNDER-FIVES) in the following areas: UNDER-FIVESs presenting with fever; the period within which UNDER-FIVESs are being brought to Health Facilities (recommended in first 24 hours of fever sign); use of MRDT in diagnosis; and, identifying any UNDER-FIVESs as Orphans/Vulnerable Children. The collection of data and the use of data for decision-making purposes was viewed as an institutional weakness across most of the Ministry of Health primary health care facilities, in the Tibu Homa Program situational analysis[21], hence why a specific area of the program focused on Data Management as part of Case Management and Supply Chain Management capacity-building.

The methodology chosen does not allow for direct attribution between training completed or data collected and a specific informed decision made about a patient's treatment, as a result. This is a more difficult causal relationship to prove in the absence of a clear review of medical files / records over a longer length of time than the allotted 14 working days. Instead, the methodology underscores the importance of Contribution Analysis [22] to this study. Qualitatively, Survey Tool 3, Question 1 helps us to make a stronger connection: *Qn1. In your opinion what are the three key things that your team/facility sees as the main gains in the following?*

[21] Tibu Homa Baseline Survey (January 2012).
[22] Contribution analysis refers to developing a step by step chain of arguments to support a credible assertion that an intervention has (or has not) made a contribution, and possibly ranking the intervention among other contributions, to an intended outcome.

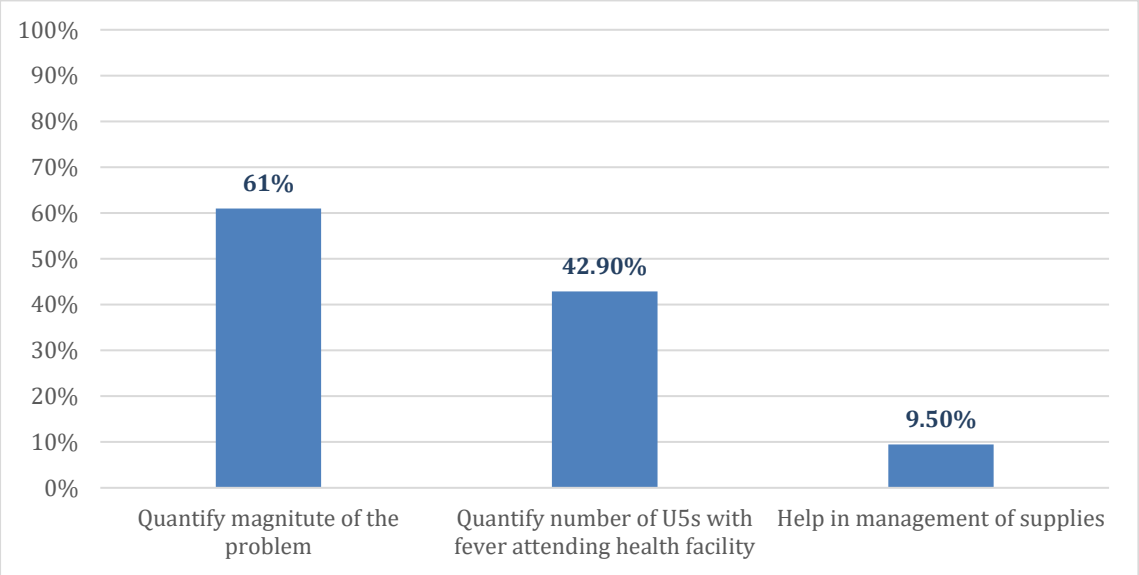
The answers provided demonstrate some evidence that Data Management is supporting better discussions on Case Management (CM) and Supply Chain Management (SCM) in facilities: Improved data use for decision-making (11/21 = 52%).

The column on mRDT is an innovation that has now been adopted by national health authorities across the region in part as a result of the advocacy of development partners who have been working in this area including the Walter Reed Society and the USAID-supported Tibu Homa Program.

The majority of respondents have felt the addition of the columns useful in understanding the magnitude of the problem of UNDER-FIVESs experiencing fever; parents and guardians response time in bringing a sick child to a facility; comparing diagnosis provided by mRDT with actual treatment given; and helping to link UNDER-FIVES OVCs with other social services in the community. The main themes identified as "useful changes" by R/CHMT staff are noted below.

New column on Under 5's presenting with fever: Regarding innovations made in MTUHA. What have you found useful about the changes in R/CHMTs Column on under-fives presenting with fever?

Bar Chart 3: Respondents perceptions on how useful the changes in HIMS register to include a column on under-fives with fever



Main themes obtained from this question were:

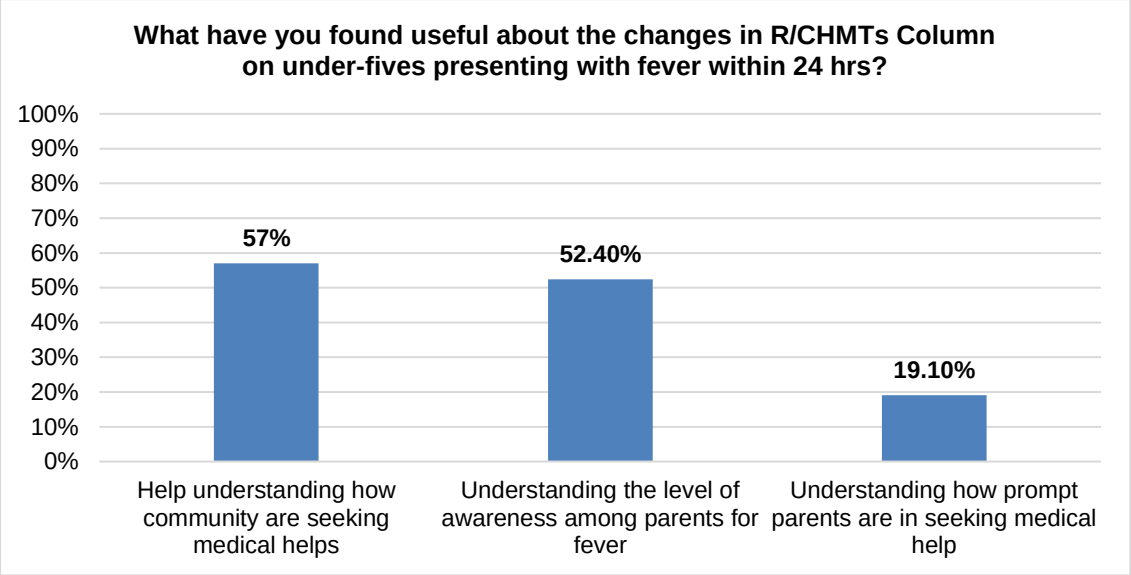
i. Quantify the magnitude of the problem (13/21=61%)
ii. Quantify number of Under Fives (UNDER-FIVES) attending health facilities (9/21=42.9%)
iii. Help the management of supply (2/21=9.5%)

New column on Under 5's presenting with fever within 24 hours: What have you found useful about the changes in R/CHMTs Column on under-fives presenting with fever within 24 hours?

Main themes obtained from this question were:

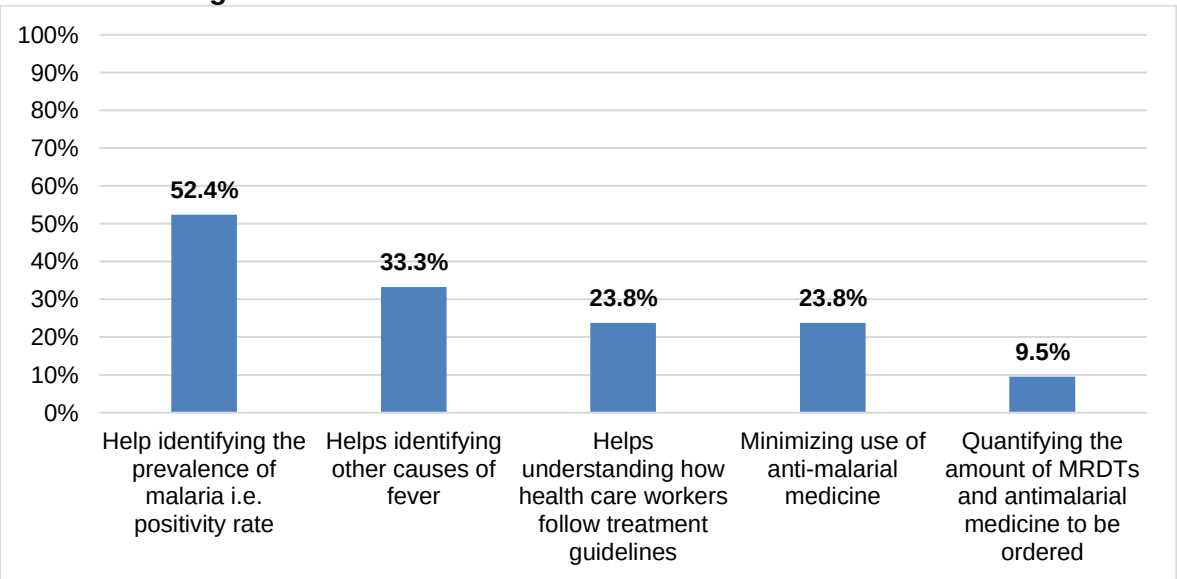
i. Help understanding how community are seeking medical helps (12/21=57%)
ii. Understanding the level of awareness among parents for fever (11/21=52.4%)
iii. Understanding how prompt parents are in seeking medical help (4/21=19.1%)

Bar Chart 4: % of respondents answers to a question: What have you found useful about the changes in R/CHMTs Column on under-fives presenting with fever within 24 hours?



New column on use of Malaria Rapid Diagnostic Test (mRDT): What have you found useful about the changes in R/CHMTs Column on mRDT?

Bar Chart 5: Respondents perceptions on a question: What have you found useful about the changes in R/CHMTs Column on mRDT?



Main themes obtained from this question were:

i. Help identifying the prevalence of malaria i.e. positivity rate (11/21=52.4%)
ii. Helps identifying other causes of fever (7/21=33.3%)
iii. Helps understanding how health care workers follow treatment guidelines (5/21=23.8%)
iv. Minimizing use of anti-malarial medicine (5/21=23.8%)

v. Quantifying the amount of MRDTs and antimalarial medicine to be ordered (2/21=9.5%)

New column on Orphan Vulnerable Children (OVCs): What have you found useful about the changes in R/CHMTs Column on OVCs?

Main themes obtained from this question were:

i. Identify under-fives who are OVCS (16/21=76.2%)
ii. Link identified OVCs with other social services (10/21=47.6%)
iii. Identify under-fives who need special care (2/21=9.5%)
iv. Data not useful (not frequently used) (2/21=9.5%)

SURVEY TOOL 1/ SECTION ON: MANAGEMENT AND ACCOUNTABILITY (R/CHMT)

Survey Results

Financial management training resulting in the implementation of action plans

- 20 people responded on behalf of R/CHMTs
- The majority had half of their staff follow financial management training marketing plans, however, there was no implementation of action points.

Funding secured as a result?

Of the 20 respondents, no one responded "Yes"; 6 replied "No"; and 12 replied "Not Applicable."

Nine written responses were provided:

- *Eight (8) members participated. Financial and audit committee formed, guidelines for audit and financial committee needed*[23]
- *Proposal was written to open hospital pharmacy*
- *Trained members (3) did not implement their marketing plan because they did not develop anything after training*
- *Not trained in Financial management*
- *Three (3) participants trained, no marketing plans (produced). Income-generating activity canteen not yet done due to lack of space*
- *Eight (8) trained but only 4 are at post; income security actually implemented in Butiama; CHF membership increased target of 36% reached*
- *No marketing plan developed after the training*
- *Four (4) trained, no marketing plan implemented. Introduced idea to other members but process is not completed. A member who was asked to take this on has left their position.*

Meanwhile, the Tibu Homa Program has worked with R/CHMTs to strengthen their membership and use of the Community Health Funds (CHF). The Ministry of Health and Social Welfare, through the Big Results Now (BRN) initiative, has noted a target of 30% enrolment by June 2015. Currently, from the Tibu Homa Program coverage, average coverage at program baseline was respectively in Missenyi (1.2%), Musoma Rural (1.4%), and Sengerema (12.3%). Now, with Tibu Homa support, these same pockets of CHMTs are showing increases in membership, however this is not a widespread trend across the covered regions. The Community Health Funds (CHF) offer a membership to families, individuals in order to access necessary medicines and supplies at no-cost to them. Hence, in many impoverished communities, the CHF serves a dual purpose of raising awareness of the

[23] The response provided indicates some measure of confusion between the purpose of Financial Management trainings and Medicines and Financial Audit Committees established.

importance of health mobilization in the community and encourages ownership and use of the services.

CHF strengthening interventions conducted
Yes -11/20
NO - 8/20
NA - 1/20

Examples of CHF strengthening activities[24]

- *March 2015 CHMT together with other local leader conducted CHF campaign in 10 villages;*
- *CHF strengthened campaign (8 wards were covered in the region);*
- *RHMT conducted February 2015 meeting and agreed that each district should try and reach 30% of CHF enrolment;*
- *CHMT has some out on mobilization. Villages and beaches. Monthly monitoring Health Facility in charge of information in recruitment numbers;*
- *Sensitization campaign, producing IDs for member by fee for service;*
- *Health governing committees ensure meeting happens, ensure board meets, dialogue with local politicians to bring in support;*
- *CHMT campaign (10 wards were covered plan to complete the remaining 10 wards on CHF sensitization);*
- *One CHF mobilization campaign conducted;*
- *One campaign was conducted for CHF mobilization; and, RHMTs supervise.*

****

Policy Changes required to improve case management:

1. MOHSW to conduct Biannual Case Management follow-up at Health facilities
2. Performance evaluation of Health Care workers conducted regularly
3. Adopting Tibu Homa column innovations for HMIS: presence of fever in UNDER-FIVES patients; presenting at health facility within 24 hours; a column on OVCs.
4. Increased frequency of supervision –- should be monthly. Technical mentorship should be separated by managerial visit.
5. National policy needs to state "testing before treatment".[25] Policy to ensure MRDT available throughout the year. Under-fives cards should be available and compulsory
6. Discipline for parents who fail to bring in their children within 24-hr window of fever onset.

[24] Provided by respondents.
[25] The MOHSW guidelines already state this as a fact. The above response was provided as part of the survey and was not altered.

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